



**Response to the
Louisiana Department
of Health and Hospitals
Transforming
Louisiana's Long Term
Services and Supports
(LTSS) System
Initial Program
Concept Paper**

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UnitedHealthcare Community & State

Introduction

UnitedHealthcare Community & State is pleased to provide comments for Louisiana's development of a Managed Long Term Services and Supports (MLTSS) program. The Department of Health and Hospitals (DHH) is to be commended for its engagement with stakeholders to develop a responsive and robust MLTSS program.

States are undergoing significant evolution in their thinking about complex populations. With the passage of the Affordable Care Act (ACA), states are given a number of new and expanded opportunities to improve access, incent rebalancing, and enhance the delivery of Medicaid long-term services and supports (LTSS).

We believe that DHH's goals are the right ones – improving access, incentivizing quality, providing the State with increased budget predictability, and ensuring adequate provider compensation. We provide comment and insight on each framework element described in DHH's Concept Paper, and look forward to continued dialogue.

1. Incorporating CMS Key Principles

To support states' move towards increasing the use of managed care to administer LTSS programs, the Centers for Medicare and Medicaid Services (CMS) developed MLTSS guidance which sets forth expectations for any new or renewing LTSS waiver authority. Through our more than 20 years' experience administering MLTSS programs in 11 states we can further validate the importance of the CMS Elements and provide practical expertise in their development, implementation, ongoing management, and evolution. DHH's framework closely follows that described in the CMS MLTSS guidance, and we provide feedback on the other elements throughout our response.¹

We focus on stakeholder engagement in this section because of its critical importance to the successful development of the MLTSS program. Stakeholders with a vested interest in MLTSS are broad and include members, caregivers, providers, community resources, and advocacy groups. Their insights and input are critical since they know this population better than anyone and their insights into members' needs is paramount to success. Their input remains critical through implementation to encourage market acceptance and during ongoing operations to further program improvements.

Stakeholders provide expertise that helps align member needs with community resources. We encourage the State to continue targeted engagement that focuses efforts on program components in which they have the most expertise [e.g., caregivers on network access issues, home and community based services (HCBS) providers on rate-related issues].

¹The CMS MLTSS Guidance identifies the following elements: adequate planning, stakeholder engagement, enhanced provision of HCBS, alignment of payment structures and goals, support for beneficiaries, person-centered processes, comprehensive integrated service package, qualified providers, participant protections, and quality.

Ongoing stakeholder engagement encourages acceptance and minimizes barriers that can occur without an effective forum for feedback.

Community Based Organizations (CBOs) play a significant and diverse role in the LTSS system, including provider, enrollment broker, care manager, and trusted advisor. Because of the wide range of capabilities, programs are more effective when plans are allowed flexibility to develop strategic relationships based on CBO expertise and population needs. Partnerships can include those with:

- Area Agencies on Aging (AAA) and other vital aging and disability agencies – To leverage their direct care, program implementation, and services
- Centers for Independent Living (CILs) – For advisory board representation, assistance with transitioning members into the community, and helping with job preparation, transportation, and peer support
- Ombudsman programs – To ensure member concerns are voiced

To maintain its focus on stakeholder engagement, DHH should contract with plans that demonstrate experience with developing and maintaining long-term engagement strategies with stakeholders. Factors such as experience developing advisory boards, leveraging existing community programs, and demonstrated expertise working with organizations and providers that assist the LTSS population should be considered during procurement.

2. Populations

We believe Louisiana should include the broadest eligible population to minimize the administrative burden of maintaining parallel fee-for-service models. This includes all individuals eligible for long-term care services: those served by HCBS waivers and nursing home residents, individuals with intellectual or development disabilities (I/DD), and individuals dually eligible for Medicare and Medicaid (dual eligibles/MMEs).

Including all eligible individuals results in better budget predictability, reduction of administrative burden associated with managing separate programs, improved market acceptance of managed care, and broad improvements in quality and program outcomes. Including broad populations and developing thoughtful program levers that incentivize nursing home avoidance will assist the State with facilitating system rebalancing. We discuss the unique program development considerations for I/DD and dual eligibles in later sections.

3. Enrollment

Our experience shows that states that adopt mandatory enrollment in MLTSS demonstrate broader success, greater market and provider acceptance, and increased program sustainability. If DHH uses an enrollment phase-in approach there are ways to accomplish this, by population or by geography. Based on the unique characteristics of those with I/DD and the State's high institutionalization rate, DHH should consider phasing in this population after the other populations, similar to Kansas. Doing so will allow the MLTSS program to



mature and afford the ability to mitigate any program challenges that could impact their transition to managed care. Another approach would be to phase in the population based on geography. The phase-in schedule would reflect natural patterns of care to minimize disruption in provider relationships. Plan engagement is also critical because plans have to so closely work with providers as individuals transition into the program.

Ongoing auto assignment by the State will need to ensure that a sufficient quantity of membership and appropriate cohort mix (to minimize adverse selection bias such as a disproportionate share of nursing home residents) is assigned to each plan to support its long-term investment. In our experience with other states, broad population inclusion combined with other program elements creates the framework to implement a system for managing individuals with a wide spectrum of medical, behavioral, and social issues. This ultimately moves the system towards improved quality and value.

4. Benefit Design

Our vision for a fully coordinated health care delivery system includes the development of an HCBS/LTSS managed care model that enables comprehensive coordination of medical, behavioral, and functional support services. As we have seen in other states, successful MLTSS program benefit designs include all available physical, behavioral, and LTSS waiver benefits (consistent with CMS' recommendation). Doing so allows plans the flexibility to align cost-effective benefits based on individual member need in a way that supports holistic care management and maintains community placement in the least restrictive setting.

In addition to benefit design, DHH should develop an approach to LTSS eligibility that makes access to HCBS benefits easier than nursing home placement to support community placement over institutionalization. States can make it easier for individuals who do not yet meet a nursing home level of care to access HCBS through opening up eligibility criteria. States already doing this include Tennessee, New Mexico, and Texas.

Lowering eligibility requirements for HCBS waiver programs to capture individuals at risk of institutionalization prior to meeting the nursing home level of care requirements ensures a health plan's ability to align cost-effective services with individuals in need who may not meet level of care criteria in an effort to delay or avoid nursing home placement.

A more progressive approach to eligibility and benefit design for consideration is adopting a tiered HCBS benefit that allows access to a small subset of benefits to beneficiaries at lower eligibility/acuity levels (for example an individual that has 2-3 functional needs). This allows limited HCBS services (e.g. meals, homemaker services) to be aligned to individuals who might be able to avoid declines with the support of less costly services in the community, thereby reducing financial exposure for DHH. UnitedHealthcare welcomes the opportunity to discuss this approach in more detail with DHH.

5. Coordination with Medicare

There are limited opportunities to achieve true integration of the Medicare and Medicaid programs outside of a few specialized programs such as the Program for All-Inclusive Care for the Elderly (PACE) and the Financial Alignment Demonstration. Developing an MLTSS program that includes dual eligibles as a mandatory population and including all eligible Medicaid and LTSS benefits (even those benefits in which Medicare is the primary payer) improves opportunities for that coordination.

MLTSS models can greatly enhance transition management for dual eligibles as they move from acute settings back to the community, minimizing unnecessary acute utilization. The State, however, needs to recognize that health plans will be limited in their ability to impact Medicare utilization given the current program opportunities available to truly integrate Medicaid and Medicare. Moving along the continuum toward greater integration is a complex process with several steps and multiple variables to consider. UnitedHealthcare has the privilege of working with states like Tennessee and Florida which are both developing innovative approaches in this area.

6. Focus on Rebalancing

The ability for individuals to have their needs met in the environment of their choice is a priority. Quality of life is significantly improved when an individual can be part of the community and live as independently as possible. Knowing that most individuals want to remain in the least restrictive setting possible, MLTSS programs should support increased access to HCBS and be informed by the service providers' ability and/or capacity to support repatriation. To support its efforts, DHH should:

- Allow health plans to help identify eligible and/or at risk members through the care coordination process, assessments, and referrals and align these members with appropriate services. This will eliminate unnecessary delays in accessing waiver services. The determination of eligibility for these services, while completed by health plans, would have independent verification from the State.
- Establish reasonable assumptions for rebalancing initiatives to identify the appropriate incentive to avoid nursing home placement and repatriate as appropriate.
- Assess the readiness of support systems, such as housing and employment support services, for clear evidence that community-based resources are in place to achieve large-scale deinstitutionalization.

The State should develop program levers that appropriately incent plans to rebalance the system. We would encourage DHH to develop a blended rate that considers costs for both nursing home placement and HCBS, weighted on the current usage of services by the population. This provides the strongest financial incentive for community placement and system rebalancing. We recommend an annual adjustment to the rate methodology benchmark using the previous year's nursing home to HCBS placement experience. This

allows for a renewed focus on rebalancing efforts as the program matures while accounting for the previous year's efforts. It is important that nursing home placement assumptions be reasonable, considering current nursing home placement rates, to appropriately weight nursing home avoidance versus repatriation to the community.

DHH should balance financial incentives with appropriately structured program performance and quality incentives to ensure rebalancing efforts do not compromise quality. Based on our experience in other states, it is important to develop incentives that target administrative performance indicators in Year 1, phasing in more clinical indicators later. This ensures the MLTSS program participants remain focused on the development of a sound program foundation during implementation.

Rebalancing efforts can be further supported through person-centered approaches to nursing facility diversion and transition management that include a care coordination process, in collaboration with members and caregivers, providers, and facility staff, to ensure necessary HCBS to support placement in the least restrictive environment. Arizona (a State where UnitedHealthcare participates) had only 5% of consumers residing in the community at program inception. Today, nearly 70% live in the community. In New Mexico, between 2009 and 2011, UnitedHealthcare reintegrated 250 nursing home residents with a 78% success rate for those remaining in community settings six months or longer after reintegration.

Key principles of nursing home diversion and transition management include:

- Promote a member empowerment culture of self-determination, self-direction, and person-centered practices responsive to individuals with an array of disabilities
- Identify members at risk for transition into a nursing facility and that may be able to transition from a facility back to the community by monitoring changes in condition
- Work with members in the nursing facility to set goals that may lead to transition back into the community
- Partner with providers to monitor for changes in condition that may lead to a nursing facility placement and ensure necessary supports to stay in the community
- Develop programs and community partnerships that help members stay in or transition to the community

7. Consumer Protections

Those enrolled in MLTSS programs are some of the most vulnerable in our states, and require special consideration. While CMS requires several components, there are additional ones we think DHH should also consider. For example, beneficiary protections should include:

- Ability for a member to switch plans within the first 90 days and for cause thereafter allowing for an open enrollment period every 12 months
- As the program matures, adjust auto-assignment algorithms to ensure greater assignment to plans with high-quality performance

- Deinstitutionalization goals for I/DD populations should balance dignity of risk with individual safety and account for market maturity to support it
- Ensure plans' ability to meet the requirements of Olmstead Agreements or Department of Justice settlement standards, if incorporated into plan contracts
- Plan demonstration of robust experience in member care transitions and working with providers and members

Recognizing that elderly and physically and intellectually disabled individuals are reliant on the care provided by MLTSS for safety and quality of life, the State might require that plans take added measures to ensure continuity of care, such as:

- Honor previously-approved prior authorizations and provider relationships for 90 days or until a new care plan is established
- Have care coordinators conduct face-to-face visits with member and their caregivers
- Conduct outreach to members to reassure them that services will continue
- Educate providers and the community about the new program

8. Providers

Contracting with qualified providers is critically important to the success of an MLTSS program. Given the very local nature of LTSS care delivery, it is important for program design to appreciate how to maximize the existing system and enhance it through expanded access and strategic relationships. Early in the process DHH can provide the list of HCBS waiver contracted providers, and the plans can send mailings to the providers that include an application and contract. Plans can send a second mailing to those that do not respond within a designated timeframe, and conduct outreach to those that do not respond to either.

Additional key considerations include:

- Any willing provider in good standing with the State should be required to participate with all plans to ensure continuity of care and to encourage market acceptance of MLTSS. After Year 1, plans should have the ability to develop high-quality networks with selected providers, while maintaining access standards.
- Consider developing financial incentives that encourage provider participation, for example, reduced fee-for-service payment (80-90%) for those who refuse to contract after multiple good faith attempts can be demonstrated
- The State should continue to set LTSS reimbursement rates, including nursing homes.
- For other acute, non-LTSS services like hospitals and physicians, plans should be allowed to develop their network as they have already been engaged and have been a part of the ongoing transformation to Medicaid managed care in Louisiana.

Provider education and training is crucial to ongoing success. Training and education should begin when providers first contract to join a network and continue with general and targeted education and training. Plans should work directly with HCBS and MLTSS providers to provide

ongoing training for billing, claims submission, and connectivity. Plans should also reach out to providers with face-to-face meetings, WebEx, and community events and forums.

MLTSS providers often lack technical sophistication; some have never submitted traditional medical claims. Plans need to provide support for them around: contracting tools and resources; processes that may impact their practice; claim issues, prior authorization problems, and other operational concerns. Our New Mexico experience speaks to the success plans can achieve – our overall HCBS provider satisfaction scores increased from 72% in 2011 to 96% in 2012, based on our action taken in response to provider feedback.

We have found that using Medicaid access requirements for LTSS is adequate as long as such requirements result in a network that is sufficient in number, mix, and geographic distribution for the service area. Over time, DHH should work with plans to balance access requirements with higher quality, focused networks.

9. Choosing Partners

We encourage the State to consider a combined procurement, selecting plans that have demonstrated deep competence across all populations, including dual eligibles and I/DD (as Kansas did, while phasing in those with I/DD later). Not only does this minimize DHH's burden of managing separate procurements, but it streamlines implementation. We have also heard from the provider community in other markets like Mississippi and Tennessee that administrative simplification is important and the number of health plans that they need to maintain a relationship with is of significant concern. Through an effectively designed program and partnership with experienced health plans, the entire MLTSS population can be managed by the same health plans.

In its procurement, DHH will want plans to:

- Provide demonstrated approaches for key MLTSS operational areas and the essential elements identified in the Concept Paper
- Have proven experience in several states with similar populations, and offer innovative methods for the challenges in MLTSS program implementation and ongoing operation

Elements that can demonstrate plans' capabilities around managing these members include:

- Assessment tools and coordination strategies that foster cost-effective service alignment based on needs and preferences
- Ability to engage with consumers to shape the program and respond to their needs
- Transition strategies and timeliness to develop patient-centered plans of care
- Approaches to population management that ensure meaningful engagement
- Staffing levels that effectively allocate resources based on member needs
- Methods to manage members with dual behavioral and physical health needs
- Capacity to build relationships with CBOs and non-traditional providers

10. Care Coordination

A comprehensive, holistic, person-centered model of care and innovative tools for use by the care coordinator and interdisciplinary care team (ICT) are critical MLTSS program components with which plans must be proficient. “Person-centeredness” puts the member first in decision making, choices, and preferences. Care coordinators ensure that members’ care plans continually reflect and incorporate member and family/caregiver preferences, level of education, and support for self-management and other resources as appropriate.

Through a person-centered, interdisciplinary approach, the program can align appropriate resources and customize engagement at the member level. By developing strategies to partner members with support programs, members are empowered with an understanding of how to access the health care delivery system; tactics to more effectively manage chronic conditions; and information to coordinate services in a manner that addresses their medical, behavioral, and social needs in a timely, cost-effective, clinically appropriate manner.

DHH might evaluate the following MLTSS program design elements during procurement that address the broader holistic, person-centered approach to care coordination (affording plans flexibility to demonstrate innovative methods that have worked elsewhere):

- Proprietary assessment tools and coordination strategies that foster the most cost-effective alignment of services based on individual needs and preferences
- Assessment timeframes as individuals transition to managed care based on member risk
- Transition strategies after completing assessments and developing plans of care within realistic timeframes
- Approaches to population management that ensure appropriate and meaningful engagement with each member based on individual needs and preferences
- Appropriate staffing levels to allow for effective allocation based on member need

Tactically, plans will need to address members who have both behavioral and physical health needs. Doing so involves several interrelated processes, including:

- Coordinate the member’s care with his or her ICT, including medical and health services directors, behavioral health consultants, social workers, developmental disabilities specialists, and consulting pharmacists
- Assist the member as a liaison to help partner with physicians and community resources
- Leverage community resources from governmental, private, and faith-based organizations, among others
- Work with the member to build a comprehensive, personalized support network that involves family, friends, neighbors, physicians, government, and CBOs

11. Measuring Quality and Outcomes

UnitedHealthcare agrees with the direction provided by CMS to the states regarding the 10 critical quality elements in LTSS as defined in the “CMS Guidance to states using 1115

demonstrations or 1915b waivers for MLTSS.” DHH will want to work toward implementing those elements over a reasonable timeframe. As noted by CMS, states should integrate oversight strategies for the MLTSS program into their overall approach to assessing quality and performance for their Medicaid managed care programs.

Quality metrics should be established based on the population served, supportive of program goals and continuous improvement. Measures should align across institutional and HCBS and incorporate other quality systems such as Money Follows the Person, Health Homes, and the Balancing Incentive Program. We provide several measures for DHH to consider (using the CMS reporting framework). Year 1 metrics often focus on administrative functions and foundational program development to ensure the appropriate focus is maintained. Years 2 and 3 development can then focus on more clinical- and outcome-related measures.

1. Network Adequacy – Measures should include those to ensure sufficient access and availability to LTSS providers, travel distance compliance, access requirements (e.g., two of each type of HCBS provider for every county), ensuring the plans have adequate capacity to meet member needs, the presence of a network development plan, and 100% compliance of credentialing and re-credentialing of providers.
2. Timeliness of Assessments – Measures should include those around percentages of members receiving timely Level of Care annual assessments and reassessments, percentage of MLTSS members receiving timely and comprehensive needs assessments upon enrollment and annually thereafter, and completion of nursing facility transition assessments.
3. Service Plans and Service Plan Revisions – Measures should include those around development of the plans with the member and his or her supports and ensuring that care coordinators understand how to develop a plan of care that meets the member’s needs and contract requirements.
4. Disenrollment – Measures should include those around maintaining eligibility, members continuing to meet MLTSS levels of care (e.g., percent of members who received annual reassessments for LOC eligibility prior to their annual recertification date).
5. Utilization Data – Measures should include those around tracking HCBS service utilization, tying back to the member’s plan of care.
6. Call Monitoring – Measures should include those around speed to answer (e.g., 85% of calls answered within 30 seconds), abandonment rate, and adequate after hours support.
7. Quality of Care Performance Measures – DHH should consider administering a member satisfaction survey to measure satisfaction with services provided, compliance with monitoring quality of care requirements, and management of critical incidents.
8. Fraud and Abuse Reporting – Measures should include those around expected compliance with fraud and abuse reporting requirements.
9. Participant Health and Functional Status – Measures should include those around monitoring member safeguards and health opportunities (e.g., percent of members with several routine medications and with documented completed advanced directives).

10. Complaint and Appeal Actions – Measures should include those around ensuring that members are notified on time and appropriately of any reduction or denial of service, and ensuring that appeals are collected immediately and resolved through established policies and procedures , following all State requirements and protocols.

Thoughtfully structured performance indicators and beneficiary protections can ensure the MLTSS program does not compromise on quality and/or put members at risk.

UnitedHealthcare has developed an approach to HCBS quality indicators based on CMS' endorsed seven quality domains, based on our national experience administering MLTSS programs. We welcome the opportunity to engage in more in-depth conversations with DHH to provide insight into our approach and lessons learned.

12. Accountability

Developing an MLTSS program that focuses on system-wide accountability is fundamental to DHH's ability to facilitate system change. Thoughtfully structured plan contract elements can assist with program oversight and establish clear expectations in measuring performance.

MLTSS contracts are complex. Developing and negotiating them necessitates cross-departmental expertise, including legal, financial, policy, and program. Managing these contracts requires close attention to standards, reporting requirements, and an understanding of how contract components influence each other.

Monitoring plan performance is critical and DHH might want to create performance incentives that address issues of particular relevance to the MLTSS population. For example, data might show high direct staff turnover, so DHH might want to evaluate plans against their success in improving that turnover and offer a potential bonus payment tied to achieving or surpassing the goal.

As noted in Section 6, establishing well-constructed rates is another key variable to fulfill the State's goals, and fundamental to program success. Effectively structured rates ensure program stability and incentivize health plans to align with program goals. For example, DHH will need to apply reasonable managed care savings assumptions to the blended rate based on opportunities to rebalance services, taking nuances within the current system into consideration. For the dual eligible and I/DD populations, the State should develop separate rate methodologies to appropriately fund the program based on their unique characteristics:

- Dual eligible rate development should adjust for the portion of expenses covered by Medicare and appropriately recognize the limited ability of health plans to achieve cost savings associated with cross-over liability services.
- A cost plus rate development for specialized populations due to the high cost associated with necessary specialized services and care coordination needs.

We support DHH's recommendation that plans achieve an 85% Medical Loss Ratio. It is a reasonable target given our experience. For more sophisticated provider practices, health



plans can be allowed to develop shared savings and/or risk arrangements to further enhance providers investment is driving performance in alignment with MLTSS program goals.

13. Implementation

Sufficient planning and transition strategies are critical to a successful program launch. We find the greatest success when states partner with community stakeholders and experienced plans during planning and implementation. This collaboration can include:

- Bringing in plan leadership from established MLTSS programs to help build requirements and work with local teams to build the product and requirements
- Participating in DHH meetings around contract requirements and implementation strategies
- Providing assistance around quality measures that work well for the LTSS population
- Effective and ongoing outreach and education – DHH’s groundwork with stakeholders will help significantly, as they can help facilitate outreach and help craft communication and education methods

The typical timeline to implement a new MLTSS program from conception to go live is 12 to 24 months. A more streamlined timeline for states that have undertaken stakeholder input and begun to develop the infrastructure, like Louisiana, could be closer to 10 months. As we noted earlier, a combined procurement which includes all MLTSS populations will likely be the most expedient and effective. States want to ensure that plans have a demonstrated track record of providing MLTSS services nationally for these populations, and a proven ability to engage with appropriate providers and stakeholders, manage and coordinate care for these complex populations, and build robust provider networks.

The strategies below can ease and improve the transition to managed care:

- Stakeholder engagement and leveraging community-based resources to effectively shape program design and assist with general implementation
- Enrollment that evaluates the unique characteristics of the existing LTSS program and supports successful transition and market acceptance of managed care
- Partnering with experienced plans that have demonstrated success in implementing and administering MLTSS programs
- Appropriately structured program performance indicators and incentives to focus on foundational program development
- Making clinical and/or claims experience data available to plans to assist with risk stratification to ensure timely identification of high-risk members
- Program flexibility that minimizes the burden on the State and health plans

Thank you for the opportunity to comment on the MLTSS program in Louisiana. We hope the approaches we have outlined provide additional guidance and insight into what UnitedHealthcare, through years of MLTSS implementations and ongoing program management, considers key elements for a successful MLTSS program. We look forward to



continued dialogue and welcome the opportunity to meet with DHH and other stakeholders as the program continues to take shape.